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No. 98-1949

IN THE
SUPREME COURT OF THE UNITED STATES

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

REPLY BRIEF OF PETITIONERS

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INTRODUCTION

In this case, the court of appeals held (1) that a health maintenance organization ("HMO") and its physicians act as fiduciaries under the Employee Retirement Income Security Act ("ERISA") when they implement a managed care program in which physicians receive financial incentives to provide medical care to HMO members in a cost-effective manner, and (2) that an allegation that an HMO and its physicians are implementing financial incentives for cost containment states a claim for breach of fiduciary duty. In opposing the petition, respondent asserts that the decision is actually narrow and therefore that neither petitioners nor their *amici* nor this Court need worry that it will cause devastating uncertainty and disruption for managed health care plans and their patients throughout the country.

Respondent chastises petitioners for misunderstanding the decision, but it is respondent who is attempting to obscure the clear holding of the court of appeals. There is no material way to distinguish the medical cost-containment incentives as analyzed by the court of appeals in this case from those in place in countless other employer-sponsored health plans.[1] There is no material way to distinguish this claim of medical malpractice from any other claims of medical malpractice involving ERISA plan participants. The panel's broad holding is that ERISA health care plans "have a fiduciary duty not to adopt HMO[s] or other managed care options," because cost-containment incentives create a conflict of interest for the health care provider. Pet. App. 54a. And the necessary effect of that

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[1] *See* Pet. 16-17; Pet. App. 57a (Easterbrook, J., dissenting from denial of rehearing *en banc*) ("If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations.").

decision is that it is "unlawful" for an ERISA plan to adopt a health care delivery program that includes such incentives. *Id.* at 56a. See also Pet. 13-18. As a result, the panel decision is inherently in tension with Congress' express authorization of HMOs, including those which establish financial incentives for providers to contain costs, as well as the States' traditional authority to regulate the field of medical malpractice. The decision is also wrong because HMOs and physicians neither act as fiduciaries nor breach any fiduciary duty by implementing cost-containment programs that include financial incentives.

Petitioners agree with respondent on one point: This decision is the first of its kind at the court of appeals level. Its immediate, mandatory impact will thus be felt "only" in the disruption of health care delivery in Illinois, Indiana, and Wisconsin; at this point, it will only *threaten* ERISA liability for health care delivery elsewhere in the nation. Unlike respondent, however, petitioners submit that these effects demonstrate that the decision is of profound national importance and will have immediate, widespread, and damaging consequences. Certiorari is fully justified.

ARGUMENT

I. THE PANEL DECISION IS BROAD AND MAY HAVE AN ENORMOUS IMPACT ON THE DELIVERY OF HEALTH CARE.

Respondent maintains that petitioners (along with Judge Easterbrook and three other court of appeals judges) have exaggerated the breadth -- and thus the impact -- of the court of appeals' holding in a variety of ways. None of her arguments withstands scrutiny.

First, respondent relies on the panel's denial that the decision holds that financial incentives for cost containment *automatically* give rise to a breach of fiduciary duty. Opp. 4. To state a claim for fiduciary breach, the panel explains, the complaint must also allege that "'the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses.)'" *Id.* at 5 (quoting *Herdrich* v. *Pegram* 154 F.3d 362, 373 (7th Cir. 1998)). In other words, to state a claim for fiduciary breach, a plan participant or beneficiary must allege (1) that the plan has implemented financial incentives for physicians or other providers to contain costs, and (2) that the incentives affected a treatment decision. This explanation emphatically *demonstrates* petitioners' point. Almost any time a physician or other provider of health care under a health plan with financial incentives for cost containment makes a treatment decision that might have been affected by those incentives, he or she will be subject to a claim for breach of fiduciary duty. Any plaintiff's attorney can allege improper purpose on that basis. Far from narrowing its decision, the panel's explanation reveals its dramatic scope.

Respondent next argues that the panel decision is limited to the particular corporate structure of the petitioners here. She points out that the physicians of Carle Clinic "employ themselves" and "control the claims processing and utilization review" of the plan and that these physicians also receive a "year-end distribution" based on the profits achieved by their own efforts at cost containment. Opp. 7-8. Respondent never explains, however, why the panel opinion is limited to managed care organizations with this particular corporate structure. Indeed, the opinion itself contains no such statement and allows no such implication. For the panel, the critical point was that

the treating physicians had a financial incentive to contain costs and that this incentive allegedly affected their treatment decisions. This situation exists in any plan where physicians have a financial incentive to contain costs.

Respondent also correctly and irrelevantly points out that there are many different types of managed care programs; that HMOs use a "wide variety of incentive plans"; and that petitioners' plan embodies only one type of incentive program. Opp. 15-16. Distinctions among types of incentive programs were not, however, critical to the panel. It focused only on the existence of financial incentives that might affect treatment decisions. The crucial point is that most health plans employ *some* kind of financial incentives for physicians to contain costs and that, under the panel opinion, every time a physician or other provider under such a plan makes a treatment decision that allegedly was affected by the incentives, he or she (and the health plan) has a conflict of interest and may be sued in federal court for an ERISA violation.[2]

Respondent further contends that the panel decision does not equate medical malpractice with a breach of fiduciary duty. In support, she points out that the medical malpractice portion of her case is not even before this Court, having already been adjudicated. But respondent is again validating petitioners' point. The same facts which constitute a state-law medical malpractice claim also give rise to a federal claim under ERISA simply because the physician's judgment was made in the context of a managed care plan which includes financial

[2] Respondent essentially admits that most HMOs include some kind of financial incentives for physicians to contain costs, *see* Opp. 15-16. The lone counter-example of Kaiser-Permanente hardly diminishes the need for review of the decision.

incentives for cost containment.[3] In other words, as petitioners' *amici* explain at greater length, the panel decision makes every treatment decision by a physician or other provider under an ERISA plan a fiduciary judgment, subject to ERISA's standards for fiduciary breach. The panel decision has thus ensured that numerous medical malpractice cases arising under state law will be filed as ERISA cases and thus will be litigated in federal court.[4]

Finally, respondent contends that the panel decision does not *inevitably* conflict with Congress' authorization of HMOs, including its express statement that HMOs may implement financial incentives for cost containment, see 42 U.S.C. § 300e(c). Opp. 18. It is, she asserts, still possible for an HMO to provide financial incentives for cost-containment without running afoul of ERISA. Petitioners' point, however, is not that the panel decision makes it legally impossible to implement any financial incentive for cost containment. Rather, the panel

[3] Respondent belittles petitioners' reference to the American Medical Association's ("AMA's") *Principles of Medical Ethics* (1994), asserting that it does not adequately protect patients from ethical breaches that also violate the law. Opp. 6. Of course, respondent ignores petitioners' real argument -- that petitioners' conduct did not violate ERISA and that there is no policy basis to stretch ERISA beyond its logical reach because state malpractice law and the AMA ethical code in combination protect patients from physician misjudgments potentially resulting from cost-containment incentives.

[4] Respondent also seems to argue that petitioners cannot claim the panel decision blurs the line between medical malpractice and breach of fiduciary duty claims, because petitioners opposed amendment of respondent's complaint to add the ERISA claim on the ground that it was not sufficiently related to the original medical malpractice claim. Opp. 17. The argument does not follow. There is no inconsistency in contending that a fiduciary breach is insufficiently related to a medical malpractice claim to allow amendment of a complaint alleging malpractice, while at the same time arguing that a malpractice claim does not allege a fiduciary breach simply because it also alleges that the malpractice was committed by a physician in a managed care plan.

decision strongly discourages such programs because any ERISA plan participant or beneficiary unhappy with a treatment decision may now file a federal lawsuit alleging that the decision was motivated by a financial incentive, rather than the patient's best interests, and thus was a violation of the fiduciary obligations imposed by ERISA. If the mechanism creates a conflict of interest in a fiduciary, it may be enjoined and the plan required to pay attorneys' fees. The panel decision is thus clearly in substantial tension with an important congressional policy choice as a result of its incorrect interpretation of ERISA. This policy is embodied not only in the HMO Act, but also in the Medicare and Medicaid Acts, which also authorize the use of financial incentives to promote cost containment by health care providers. See Pet. 15.

II. PETITIONERS DID NOT ACT AS FIDUCIARIES WHEN THEY IMPLEMENTED COST-CONTAINMENT INCENTIVES.

Under ERISA, a person is a fiduciary only "to the extent" that he or she is engaged in one of the activities that ERISA defines as fiduciary. Pet. 19. When that person is engaged in other activities that involve the exercise of discretion, he or she is not acting as a fiduciary even though that exercise of discretion may substantially affect the plan. *Id.* Put differently, ERISA allows persons who are fiduciaries to have dual loyalties. Petitioners in this case are ERISA fiduciaries for some purposes, but they did not act as fiduciaries when they established and implemented the cost-containment incentives in the plan at issue.

Respondent thus entirely misses the point when she argues that petitioners must be fiduciaries because they argued below that they are fiduciaries for a particular purpose. Specifically, respondent points out that when she amended her

complaint for the first time, she added the original Count III, in which she asserted that Carle Clinic *failed to disclose* certain material facts regarding the ownership of Health Alliance in violation of the Illinois Consumer Fraud Act. See Pet. App. 76a. In response, petitioners argued that they were ERISA fiduciaries *for this purpose* (*i.e.*, the disclosure of information to plan participants and beneficiaries); that ERISA contained detailed disclosure requirements; and that the state-law disclosure claim was preempted by ERISA. The lower court agreed. See *id.* at 76a-79a. Petitioners freely acknowledge that they are plan fiduciaries when they engage in activities denominated as fiduciary by ERISA, *e.g.*, when they provide information to participants as required under ERISA and when they make decisions about who is eligible for plan benefits. But petitioners' every decision is not fiduciary in nature. See Pet. 20-22. And petitioners' contention in the district court that they acted as plan fiduciaries for certain purposes does not mean that they are "arguing with themselves" when they assert in this Court that they are not acting as plan fiduciaries when they implement cost-containment incentives. Opp. 6.[5]

The panel made the same error that respondent makes. It stated that "tolerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibilit[ies] . . . in favor of 'loyalty' to his own financial interests." Opp. 5 (quoting *Herdrich* v. *Pegram* 154 F.3d 362, 373 (7th Cir. 1998)). A fiduciary has not jettisoned his

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[5] Respondent demonstrates that two district courts have decided that HMOs are fiduciaries when they make discretionary decisions related to plan assets, as if that were dispositive of the question here. *See* Opp. 20-21. But petitioners concede that many HMOs, including Carle Clinic, are fiduciaries for certain purposes. Neither of the cases cited addresses the question presented here, which is whether a managed care plan is acting as a fiduciary when it implements financial incentives for cost containment.

responsibilities when he is "loya[l] to his own financial interests" while making *non-fiduciary* decisions. Pet. App. 22a. See Pet. 20-25. ERISA's tolerance of dual loyalties plainly extends to such situations. See, *e.g.*, *Hughes Aircraft Co.* v. *Jacobson*, 119 S. Ct. 755, 762-63 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890-91 (1996).[6]

III. THE QUESTION PRESENTED WAS SQUARELY DECIDED BY THE COURTS BELOW.

Respondent argues that this Court should not grant the petition because petitioners did not "[p]reserve [t]heir [a]rguments" in the courts below. Opp. 13. This argument is frivolous.

First, even a cursory review of the panel decision and the dissent from denial of rehearing *en banc* reveals that the parties addressed and the court thoroughly analyzed and decided the question presented. See, *e.g.*, Pet. App. 10a ("defendants next contend that Herdrich has failed to state a cause of action for breach of a fiduciary duty under ERISA"). In lengthy opinions, the panel concluded that the complaint adequately pled that petitioners were ERISA fiduciaries who had breached their duty under that Act, *id.* at 11a-37a, and the panel dissent and the dissent from denial of rehearing disagreed with the panel on both points, *id.* at 39a-44a, 52a-58a.

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[6] Respondent seems to distinguish *Hughes Aircraft* and *Lockheed Corp.* on the ground that the former involved a pension plan and that both involved a plan sponsor. Neither distinction is relevant to petitioners' point. These cases stand for the proposition that an ERISA fiduciary is not a fiduciary for all purposes, so that the fact that petitioners may "have declared themselves to be ERISA fiduciaries" in one context is not dispositive in other contexts, no matter how many times respondent says so. Opp. 20.

Respondent finds it significant that in the court of appeals, petitioners made the alternative argument that there was no final judgment for the court of appeals to review. The court of appeals rejected this argument and petitioners did not seek review of that holding. We are aware of no authority that an appellant who makes an alternative jurisdictional argument fails to preserve all of the other arguments it actually presented below.

Next respondent argues that "[a]t no point during the initial appeal did petitioners argue 42 U.S.C. § 300(e) or 42 C.F.R. § 417. 479." Opp. 13. Respondent conveniently ignores that both of these provisions are mentioned in opinions in the court of appeals, see Pet. App. 44a, 58a, and concedes that both were cited in the petitions for rehearing, Opp. 14. In any event, petitioners are citing these provisions only as further support for arguments already made. Once a federal issue is properly raised, a party can make any argument in support of its position on that issue. "[P]arties are not limited to the precise arguments they made below." *Yee* v. *City of Escondido*, 503 U.S. 519, 534 (1992) (citing, *inter alia*, *Bankers Life & Cas. Co.* v. *Crenshaw*, 486 U.S. 71, 78 n.2 (1988)); *id.* at 535 ("[h]aving raised a . . . claim in the [lower] courts, . . . petitioners could have formulated any argument they liked in support of that claim here").

Finally, respondent claims that the procedural posture of the case, which was dismissed at the pleading stage, makes certiorari review inappropriate. She asserts that it is unclear whether the plan was self-insured or insured, which HMO model Carle Clinic embodied, and whether the Carle Clinic was federally qualified. Opp. 14-15. But none of these facts is material to the question presented, because none would alter the panel decision that when an ERISA plan makes a decision that is merely alleged to have been motivated by financial incentives

for cost containment, it breaches its fiduciary duty to its participants and beneficiaries. Indeed, the procedural posture of the case serves starkly to illuminate the purely legal question presented: Whether HMOs and physicians are acting as fiduciaries and breach their fiduciary duty under ERISA when they implement financial incentives for cost containment.

* * * *

The petition shows that the court of appeals has issued an incorrect decision that is in tension with congressional policy and decisions of this Court. Its consequences are damaging and disruptive to numerous health care providers under ERISA plans. As Judge Easterbrook explained, if the decision stands, then "the principal organizational forms through which medical care is delivered today are unlawful" when employed by an ERISA plan. Pet. App. 56a (Easterbrook, J., dissenting from denial of rehearing *en banc*). These consequences are engendered by a substantial and unwarranted expansion of the scope of fiduciary liability under ERISA. The substantial effects of this erroneous decision on one of the most important sectors of the national economy make this case worthy of the Court's full review.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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